No. 90-960

FILED
DEC 12 1990
JOSEPH F. SPANIOL, JR.
CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1990

JAMES C. CATHEY and BETTE CATHEY,
Petitioners

V.

THE DOW CHEMICAL COMPANY
MEDICAL CARE PROGRAM,
Respondent

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

APPENDIX TO PETITION

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APPENDIX A

STATUTES INVOLVED

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

§ 1132. Civil enforcement.

(a) Persons empowered to bring a civil action

A civil action may be brought—

(1) by a participant or beneficiary—

* * *

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan[.]

§ 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

* * *

(2)(A) Except as provided in subparagraph (B),

nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

* * *

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law.

McCARRAN-FERGUSON ACT

CHAPTER 20 - REGULATION OF INSURANCE

§ 1011. Declaration of policy

Congress declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the

Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

§ 1012. Regulation by State Law; Federal law relating specifically to insurance; applicability of certain Federal laws after June 30, 1948.

(a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

TEXAS INSURANCE CODE

Art. 21.21. Unfair Competition and Unfair Practices

Declaration of purpose

Sec. 1. (a) The purpose of this Act is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress

of March 9, 1945 (Public Law 15, 79th Congress)[1], by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

(b) This Article shall be liberally construed and applied to promote its underlying purposes as set forth in this section.

* * *

Relief available to injured parties

Sec. 16. (a) Any person who has sustained actual damages as a result of another's engaging in an act or practice declared in Section 4 of this Article or in rules or regulations lawfully adopted by the Board under this Article to be unfair methods of competition or unfair or deceptive acts or practices in the business of insurance or in any practice defined by Section 17.46 of the Business & Commerce Code, as amended, as an unlawful deceptive trade practice may maintain an action against the person or persons engaging in such acts or practices.

(b) In a suit filed under this section, any plaintiff who prevails may obtain:

(1) the amount of actual damages plus court costs and reasonable and necessary attorneys' fees. If the trier of fact finds that the defendant knowingly committed the acts complained of, the court shall award, in addition, two times the amount of actual damages; or

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[1] 15 U.S.C.A. §§ 1011 to 1015.

(2) an order enjoining such acts or failure to act; or

(3) any other relief which the court deems proper.

Texas Deceptive Trade Practices — Consumer Protection Act

Ch. 17, Texas Business & Commerce Code

Sec. 17.50. Relief for Consumers

(a) A consumer may maintain an action where any of the following constitute a producing cause of actual damages:

(1) the use or employment by any person of a false, misleading, or deceptive act or practice that is specifically enumerated in a subdivision of Subsection (b) of Section 17.46 of this subchapter;

(2) breach of an express or implied warranty;

(3) any unconscionable action or course of action by any person; or

(4) The use or employment by any person of an act or practice in violation of Article 21.21, Texas Insurance Code, as amended, or rules or regulations issued by the State Board of Insurance under Article 21.21, Texas Insurance Code, as amended.

TEXAS STATE BOARD OF INSURANCE — RULES AND REGULATIONS

28 Texas Administrative Code

§ 21.1. Deceptive Acts or Practices of Insurers, Agents, and Connected Persons

Purpose of Regulation. It is the purpose of these sections to further define and state the standards that are necessary to prohibit deceptive acts or deceptive practices by insurers and insurance agents and other persons in their conduct of the business of insurance or in connection therewith, whether done directly or indirectly, and irrespective of whether the person is acting as insurer, principal, agent, employer, or employee, or in other capacity or connection with such insurer.

* * *

§ 21.3. Unfair Trade Practices Prohibited

(a) Misrepresentation of insurance policies, unfair competition, and unfair practices by insurers, agents, and other connected persons are prohibited by Article 21.20 and Article 21.21 or by other provisions of the INSURANCE Code and by these sections of the State Board of Insurance. No person shall engage in this state in any trade practice that is a misrepresentation of an insurance policy, that is an unfair method of competition, or that is an unfair or deceptive act or practice as defined by the provisions of the Insurance Code or as defined by the sections and other rules and regulations of the State Board of Insurance authorized by the Code.

(b) Irrespective of the fact that the improper trade practice is not defined in any other section of these rules and regulations, no person shall engage in this state in any trade practice which is determined pursuant by law to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

§ 21.4. Misrepresentation Defined; Standards for Determining Misrepresentation

The term misrepresentation, or the prohibited conduct, act, or practice that constitutes misrepresentation by a person subject to the provisions of these sections, is defined as any one of the following acts or omissions:

(1) any untrue statement of a material fact; or

(2) any omission to state a material fact necessary to make the statements made (considered in the light of the circumstances under which they are made) not misleading; or

(3) the making of any statement in such manner or order as to mislead a reasonably prudent person to a false conclusion of a material fact; or

(4) any material misstatement of law; or

(5) any failure to disclose any matter required by law to be disclosed, including failure to make disclosure in accordance with the provisions of these sections and other applicable rules of the State Board of Insurance.

* * *

SUBCHAPTER 3. UNFAIR CLAIMS SETTLEMENT PRACTICES

§ 21.21. Short Title

These regulations sshall be known as the Unfair Claims Settlement Practices Rules.

* * *

§ 21.203. Unfair Claim Settlement Practice

No insurer shall engage in unfair claim settlement practices. Unfair claim settlement practice means committing or performing with such frequency as to indicate a general business practice of any of the following:

(1) Misrepresenting to claims pertinent facts or policy provisions relating to coverages at issue.

(2) Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies, provided that "pertinent communications" shall exclude written communications that are direct responses to specific inquiries made by the insurer after initial report of a claim. An acknowledgement within 15 working days is presumed to be reasonably prompt.

(3) Failing to adopt and implement reasonable standards for prompt investigation of claims arising under its policies.

(4) Not attempting in good faith to efectuate prompt, fair, and equitable settlements of claims submitted in which liability has become reasonably clear;

(5) Compelling policyholders to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them;

(6) Failure of any insurer to maintain a complete record of all complaints which it has received during the preceding three years or since the date of its last examination by the Commissioner of Insurance, whichever time is shorter. . . .

(7) Failing to provide promptly, when provided for in the policy, claim forms when the insurer requires such forms as a prerequisite for a claim settlement.

(8) Not attempting in good faith to settle promptly claims where liability has become reasonably clear under one portion of the policy in order to influence settlement under other portions of the policy coverage. (This provision does not apply to those situations where payment under one portion of coverage constitutes evidence of liability under another portion of coverage).

(9) Failing to provide promptly to a policyholder a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

(10) Failing to affirm or deny coverage of a claim to a policyholder within a reasonable time after proof of loss statements have been completed. The taking of a nonwaiver agreement or the submission of a reservation of rights letter by an insurer to the policyholder

within a reasonable time is deemed compliance with the provisions of this paragraph.

(11) Except as may be specifically provided in the policy, to refuse, fail, or unreasonably delay offer of settlement under applicable first-party coverage on the basis that other coverage may be available or third parties are responsible in law for damages suffered.

(12) Attempting to settle a claim for less than the amount to which a reasonable person would have believed she/he was entitled by reference to written or printed advertising material accompanying or made part of an application.

(13) Undertaking to enforce a full and final release from a policyholder when, in fact, only a partial payment has been made. (This provision shall not prevent or have application to the compromise settlement of doubtful or disputed claims).

(14) Failing to establish a policy and proper controls to make certain that agents calculate and deliver to policyholders or their assignees funds due under policy provisions relative to cancellation of coverage within a reasonable time after such coverages are terminated.

(15) Refusing to pay claims without conducting a reasonable investigation based upon all available information.

(16) Failing to respond promptly to a request by a claimant for personal contact about or review of the claim.

(17) With respect to the Texas personal auto policy, to delay or refuse settlement of a claim solely because there is other insurance of a different type available to satisfy partially or entirely the loss forming the basis of that claim. The claimant who has a right to recover from either or both insurers is entitled to choose under which coverage and in what order payment is to be made.

* * *

§ 21.205. Minimum standard of Performance

All insurers shall maintain their affairs so that no unfair claims settlement practices are committed and the minimum standard of performance for all insurers (as that term is used in the Insurance Code, Article 21.21-2) is to comply with the provisions of § 21.203 of this title (relating to Unfair Claims Settlement Practices).

APPENDIX B

James C. CATHEY and Bette Cathey,
Plaintiffs-Appellants,

v.

The DOW CHEMICAL COMPANY
MEDICAL CARE PROGRAM,
Defendant-Appellee.

No. 89-2971

Summary Calendar.

United States Court of Appeals,
Fifth Circuit.

Aug. 3, 1990.

Participant in health plan governed by the Employee Retirement Income Security Act (ERISA) sought reinstatement of prior home nursing benefits and declaration of rights of future benefits. The United States District Court for the Southern District of Texas, Norman W. Black, J., held that fiduciary's adverse determination of benefits was not actionable under ERISA, and participants appealed. The Court of Appeals, Jerry E. Smith, Circuit Judge held that: (1) participants were not entitled to around-the-clock home nursing benefits under terms of plan, but (2) participants were minimally entitled to 50 home nursing visits annually, if medically prescribed, and were due measure of noncustodial nursing services provided during such visits.

Affirmed in part, reversed in part, and remanded.

Joe K. Longley, Mark L. Kincaid, Longley & Maxwell, Austin, Tex., James W. Patterson, Patterson & Patterson, Houston, Tex., for plaintiffs-appellants.

A.J. Harper, II, Katherine D. Hunt, Fulbright & Jaworski, Houston, Tex., for defendant-appellee.

Appeal from the United States District Court for the Southern District of Texas.

Before HIGGINBOTHAM, SMITH, and BARKSDALE, Circuit Judges.

JERRY E. SMITH, Circuit Judge:

We undertake the painful task of denying certain medical benefits to a severely handicapped plaintiff, which were formerly available to her at home to treat her degenerative disease. However, "it is the duty of all courts of justice to take care, for the general good of the community, that hard cases do not make bad law." *United States v. Clark*, 96 U.S. 37, 49, 24 L.Ed. 696 (1877) (Harlan, J., dissenting) (quoting Lord Campbell in *East India Co. v. Paul*, 7 Moo. P.C.C. 111). Accordingly, we take particular care to ensure that our legal analysis is not influenced by the plaintiff's unfortunate health, even though the outcome may pinch the emotions.

Bette Cathey suffers from severe multiple sclerosis and is almost completely debilitated. For about two years, she elected to receive eight hours of daily home nursing care, although her physician prescribed around-the-clock nursing services. Cathey's nursing benefits, however, were terminated in 1985 by her health care provider, the Dow Chemical Medical Care Program (Dow Program), under the theory that her newly elected coverage plan excludes

"custodial" care and that the nature of her nursing services were "predominantly custodial."

Cathey and her husband, a retiree of the Dow Chemical Company (Dow), instituted this civil enforcement action under the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1132. They seek reinstatement of prior nursing benefits allegedly due under the Dow Program and a declaration of rights to future benefits. *See id.* § 1132(a)(1)(B). The Catheys also wish to recover damages and attorneys' fees.

The Catheys maintain that the termination of their former home medical care benefits was abusive and in contravention of the terms of the Dow Program's coverage. After a bench trial, the district court held that the fiduciary's adverse determination of benefits was not actionable under ERISA. We are asked to decide, under the appropriate standard of judicial review regarding benefit determinations, whether Cathey's nursing services are custodial and therefore excluded from coverage. We affirm in part and reverse in part.

I.

James Cathey is a retiree of Dow and a covered participant in the Dow Program, an employee welfare benefit program governed by ERISA. His wife, Bette, is a beneficiary of the same program. *See* 29 U.S.C. § 1002(8) (West Supp. 1990). Metropolitan Life Insurance Company (Metropolitan) serves as the Dow Program's designated claims fiduciary.[1]

---

[1] An ERISA fiduciary must discharge its duties with the diligence of a prudent person, in accordance with the documents and instruments governing the plan, and solely in the interests of the beneficiaries and

Bette Cathey is incapable of engaging in the simplest chores of self-care. During 1982-84, the Catheys participated in a retiree health benefit plan styled colloquially by the Dow Program as the "Old Plan." The Old Plan's benefits include private-duty bedside nursing services, at home or in a hospital, up to a total lifetime maximum of $50,000. In December 1984, however, the Catheys elected coverage under the "New Plan," offered by the Dow Program to control escalating health costs.[2]

The claims fidiciary construes the New Plan as foreclosing the home nursing care formerly enjoyed by the Catheys. The New Plan explicitly provides,

> Typical services available through approved home health care agencies—and eligible for Plan coverage—include those of registered nurses, licensed practical nurses, home health aides, and inhalation, physical, and speech therapists. *However, expenses related to services for housekeeping or custodial care are not covered by the Plan.* [Emphasis added.]

Custodial care is defined as that designed "primarily to meet personal needs and [which] could be provided by persons without professional skills or training." A physician must attest to the necessity of home nursing care, which was done repeatedly by Cathey's personal physician upon request. Significantly, under the New Plan such care is limited to a "maximum of 50 home health care visits to any covered individual in any calendar year." Accordingly around-the-clock home nursing care, even if "medically

---

Footnote 1 continued.
participants. 29 U.S.C. § 1104(a)(1); *Offutt v. Prudential Ins. Co.*, 735 F.2d 948, 950 (5th Cir. 1984).

[2] The New Plan promised lower contributions for participants but, as a tradeoff, less comprehensive coverage.

necessary," is purportedly unavailable under the New Plan; purely custodial care is excluded altogether.

In 1981, Cathey's physician, Dr. Torp, first prescribed around-the-clock home nursing to treat her progressive multiple sclerosis. In October 1982, Cathey hired a registered nurse to provide a daily eight-hour shift of private nursing care instead, while her husband remained unavailable at work. The Dow Program paid all claims presented by the Catheys, even though the claims fiduciary initially challenged the medical necessity of the home nursing care. Once Torp confirmed the medical necessity of skilled nursing care for Cathey's condition to the fiduciary's satisfaction, however, the Dow Program fully honored Cathey's nursing claims pursuant to the benefits of the Old Plan.

The fiduciary subsequently challenged Cathey's home nursing care in 1983, and again in 1984, soliciting precise identification of the registered nurse's duties from both Torp and the nurse, as well as of the time dedicated to each activity.[3] Cathey's attending nurse performed

---

[3] In November 1984, Torp responded to the fiduciary's renewed inquiry with the following letter:

> The above captioned patient has been under our care for the past several years. The services of round-the-clock [sic] nurses have been recommended for Mrs. Cathey.
>
> The nurses[sic] duties would include supervision of Mrs. Cathey's medical condition in addition to implementation of orders as prescribed by the physical and occupational therapist. Also Mrs. Cathey is subject to seizures and if these should occur the nurses have been instructed to institute standard seizure procedures.
>
> The nurses are further instructed to monitor Mrs. Cathey's blood pressure and administer her medications as

those services directed by Torp, such as administering medication, observing vital signs and bedsores, and providing emergency treatment in the event of seizure. Further, the nurse engaged in certain speech, physical, and occupational therapy and submitted written reports to Torp every four months. The fiduciary places great significance on the fact that the attending nurse also assisted Cathey in daily, mundane activities: bathing, clothing, preparing special foods, assisting Cathey in and out of bed, and serving as a companion.

Despite Torp's assertions to the contrary, the claims fiduciary concluded that the services provided by the registered nurse were in fact "primarily custodial in nature" and could be performed by an untrained attendant. The claims fiduciary initially recommended an apportionment of the daily cost of the nurse, with the Dow Program financing only the skilled portion of the services rendered (determined by the fiduciary to be three hours daily). In February 1985, however, the Dow Program selected the draconian measure of terminating Cathey's home nursing care benefits completely, on the premise that no medical treatment was being provided by the nurse and that only licensed therapists could administer to her other health needs. The Catheys have since declined to finance privately the daily nursing care.

The Dow Program notified the Catheys that their

Footnote 3 continued.

prescribed. They have been advised to communicate with us periodically by letter and by phone regarding Mrs. Cathey's progress.

The nursing services required can be administered either by a registered nurse or a licensed vocational nurse.

physician's prescribed around-the-clock home nursing could not be financed under the New Plan, freely elected by them for coverage only a few months earlier in December 1984. Instead, according to the claims fiduciary, the New Plan contemplates only fifty nursing visits per calendar year. Those visits, in addition, must provide medically necessary services and not, as alleged here, predominantly custodial services.

The Catheys exhausted their administrative remedies in seeking, minimally, reinstatement of their prior nursing benefits. Having secured no relief administratively, they commenced this ERISA suit to enforce lost benefits, secure damages and attorneys' fees, and identify future benefits owed to them pursuant to the Dow Program.

The district court upheld the fiduciary's denial of nursing benefits, concluding that the "predominant nature" of the nursing services was custodial and did not require a skilled registered nurse, despite the physician's medical appraisal to the contrary. The court admitted, however, that certain therapy exercises provided by the registered nurse here, if done by a licensed therapist instead, are covered by the New Plan. Presumably, the attending nurse failed to provide skilled therapy as contemplated by the New Plan, although the fiduciary has never challenged the nurse's qualifications generally, and no authority has been cited to us mandating such specialization for treatment.[4]

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[4] Despite the Dow Program's self-serving assertions, we find nothing in the record or in the New Plan requiring only licensed therapists, as opposed to registered nurses, in the administration of simple physical, speech, or occupational therapy. We observe that, unless the plan mandates such specialization, courts should decline to second-guess the

The court held that the denial of home nursing services did not constitute an abuse of discretion, believed to be the appropriate standard of judicial review for benefit determinations under an ERISA-regulated plan. Alternatively, reviewing the fiduciary's determination *de novo*, the court concluded that the Dow Program engaged in a reasonable decision, consistent with the terms of the relevant instrument.

On appeal, the Catheys maintain that the appropriate standard of review for the fiduciary's denial of this claim is *de novo* review. That being so, they argue, the evidence establishes that the nursing services at issue here were not primarily—or predominantly—custodial. Specifically, the Catheys urge that incidental services provided gratuitously by the registered nurse do not operate to transform otherwise medically necessary and prescribed services into custodial services. In response, the Dow Program asserts that under either a *de novo* or abuse-of-discretion standard, the district court properly concluded that around-the-clock nursing care is not available under the New Plan and that the former nursing services at issue are entirely nonrecoverable.

II.

The appropriate standard of judicial review regarding benefit determinations by ERISA-regulated

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Footnote 4 continued.
medical care prescribed by personal physicians, as they are most qualified to gauge the therapy needed and the likely rewards inherent in such treatment. Of course, the recoverable costs or benefits owed by the Dow Program will depend upon the degree of professional skill prescribed by the physician. That is, it may not be reasonable for a home care nurse to claim that her services are commensurate with those of licensed therapists.

fiduciaries is defined in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989). The *Bruch* Court held that established principles of trust law dictate "that a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Id.* 109 S.Ct. at 956; *accord Gonzales v. Prudential Ins. Co.*, 901 F.2d 446, 449 n. 5 (5th Cir. 1990); *Barnett v. Petro-Tex Chem. Corp.* 893 F.2d 800, 808 (5th Cir. 1990), *petition for cert. denied.* ___ U.S. ___, 110 S.Ct. 3274, ___ L.Ed.2d ___ (1990).

[1,2] Accordingly, the relevant language of the ERISA-regulated health plan, if unambiguous, is reviewed *de novo* for purposes of determining the discretion retained by the plan administrator or fiduciary.[5] If the plan confers such discretionary judgment, judicial review of eligibility determinations is limited to the "abuse of discretion" standard. *Jordan v. Cameron Irons Works, Inc.*, 900 F.2d 53, 56 n. 1 (5th Cir. 1990); *Batchelor v. International Bhd. of Elec. Workers Local 861 Pension & Retirement Fund*, 877 F.2d 441, 442 (5th Cir. 1989). If, in contrast, the ERISA-governed plan does not vest discretionary authority with the plan administrator or fiduciary, or is silent regarding such author-

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[5] *Lowry v. Bankers Life & Casualty Retirement Plan*, 871 F.2d 522, 525 n. 5 (5th Cir.) (per curiam), *cert. denied*, ___ U.S. ___, 110 S.Ct. 152, 107 L.Ed.2d 111 (1989). There, we recognize that some ERISA-regulated instruments may present factual questions, and we declined to address whether federal courts are entitled, without exception, to determine the discretionary or nondiscretionary authority of ERISA fiduciaries as a matter of law. *See id.* Where, as here, the relevant plan language is unambiguous, a legal determination is merited. *Id.* We defer to a later occasion the determination of whether questions of fact concerning the discretionary nature of an ERISA plan fall within the purview of the reviewing court as well.

ity, judicial deference terminates, and eligibility determinations are reviewed *de novo*. *Bruch* 109 S.Ct. at 956; *Schultz v. Metropolitan Life Ins. Co.*, 872 F.2d 676, 678 (5th Cir. 1989).

The practical significance of *de novo* judicial review, as opposed to a more deferential standard, is that a federal court is more likely to disagree with a fiduciary's benefit determination. *Orozco v. United Air Lines, Inc.*, 887 F.2d 949, 953 (9th Cir. 1989) (per curiam). Not surprisingly, post-*Bruch* litigation has focused upon the language of ERISA-regulated plans and whether the instruments vest discretionary authority concerning entitlements with the fiduciary or administrator. Since this inquiry defines the rigor of our review, fiduciaries or administrators have argued increasingly that the instrument language expressly—or impliedly—grants to them discretionary authority over entitlements, which can be reversed only in the event such discretion is abused.

The courts of appeals that have considered, since *Bruch*, the discretion granted by ERISA instruments consistently have rejected the argument that discretionary authority can be *implied* from the instrument's language. *See, e.g., Moon v. American Home Assur. Co.*, 888 F.2d 86, 88 (11th Cir. 1989); *Orozco*, 887 F.2d at 952; *Brown v. Ampco-Pittsburgh Corp.*, 876 F.2d 546, 550 (6th Cir.1989). Absent an *express* grant of discretion over entitlement determinations, the deferential review operates adversely, as the *Bruch* Court remarked, to "afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted." 109 S.Ct. at 956. Accordingly, "the circuit courts which have found that particular ERISA plans granted discretion to plan administrators or fiduciaries, in cases decided after *Firestone*, have uniformly rested this finding upon *express language* of the ERISA

plan before them." *Moon*, 888 F.2d at 88 (emphasis in original).

[3] The Dow Program argues that certain portions of the New Plan's language create, "without ambiguity," discretionary decision making authority regarding entitlements.[6] We disagree. The Catheys are correct that much of the language relied upon by the Dow Program has

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[6] The relevant "unambiguous" plan language cited by the Dow Program as conferring discretion upon the fiduciary is derived from three separate paragraphs of a document restating the terms of the Dow Program. In full context, these paragraphs provide.

> FURTHER RESOLVED, that in accordance with Sections 1 and 6 of each plan, this Board hereby delegates to *the USA Benefits Department the authority to correct any defect, supply any omission or reconcile any inconsistency in, and to control and manage* the operation and administration of *the plans.*
>
> . . . . . .
>
> *Named Fiduciary.* The Company shall be the Administrator of the Plan. Except as provided in paragraph 4, the Company shall also be the Named Fiduciary of the Plan. *The company shall have authority to control and manage the* operation and *administration of the Plan* unless and until its Board of Directors appoints a successor. The Plan Administrator may allocate responsibilities for the administration of the Plan to other persons, whether or not Named Fiduciaries, by delivering to the Company a signed written instrument specifying the nature and extent of the fiduciary responsibilities allocated and the person or persons who are designated to carry them out.
>
> . . . . . .
>
> *Benefits Claims Procedure.* The review and final decision on a claim for benefits under the insurance policy described in paragraph 2 shall be made by the insurance company that

been taken, misleadingly, out of context from three separate paragraphs in a document restating the New Plan. The first paragraph is silent with respect to the discretion reserved by the fiduciary regarding benefit determinations generally. The second paragraph recites the truism that the fiduciary shall manage the plan *until such time as a successor is appointed.* The third paragraph allocates authority (not discretion) to review claims, as between the plan administrator (Dow) and the plan fiduciary (Metropolitan). It does not, as the Dow Program suggests, expressly confer discretionary authority regarding entitlements upon the fiduciary.

Since *Bruch*, we have had several occasions to consider ERISA instruments that granted precise discretionary authority. Significantly, the express language in those instruments is unambiguous in its design to grant discretion regarding entitlements to the fiduciary or administrator. In *Lowry*, for instance, an ERISA-regulated retirement plan conferred upon the administrator the power "to determine all questions arising" in the administration of the plan, "including the power to determine the rights or eligibility of Employees and Participants and their beneficiaries, and the amounts of their respective interests." 871F.2d at 524. Further, the

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Footnote 6 continued.

> issued the policy substantially in accordance with the welfare benefit claims procedure of the [Dow Chemical] Company attached hereto and such insurance company (and *not* the Plan Administrator) shall be the "Named Fiduciary" of the Plan with regard to any review and *final decision on a claim for benefits* under such policy.

[Emphasis represents those portions cited by the Dow Program in its brief.]

administrator's determinations were held to be "binding on all persons." *Id.* We concluded in *Lowry* that the unambiguous language of the instrument "mandates deference to the plan administrators under the circumstances of this case." *Id.* at 524-25; *see also Jordan*, 900 F.2d at 55 (deference mandated because instrument expressly gives administrator broad power to determine eligibility).

Similarly, in *Batchelor* we applied deferential review to a fiduciary's determination regarding pension benefits because the instrument provided, among other things, that the fiduciary shall "have full and exclusive authority to determine all questions of coverage and eligibility." 877 F.2d at 443. The instrument language at issue here is much less precise than that in *Lowry*, *Jordan*, and *Batchelor* and, when viewed in context, is silent regarding the discretion retained by the fiduciary to make claims determinations. Accordingly, the New Plan cannot be read as granting discretion expressly, and thus we will review *de novo* the fiduciary's denial of Cathey's nursing claims here. Having the benefit of prior judicial review, however, we will not upset the district court's factual determinations unless they are clearly erroneous. Fed.R.Civ.P. 52(a); *accord Offutt*, 735 F.2d at 949.

III.

[4] The Catheys wish to restore, at a minimum, the Old Plan's home nursing benefits formerly enjoyed by them for two years. For reasons not evident from the record, they elected to substitute New Plan coverage in place of that incident to the Old Plan.[7] The conclusion is

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[7] New Plan home nursing care is, undoubtedly, less generous than that formerly provided under the Old Plan. The New Plan expressly provides,

inescapable that the Catheys made a choice that they fully regret. Indeed, they rely heavily upon the language and definitions in the former instrument as authority for the more generous nursing care purportedly owed to them now. We conclude, however, that the language of the Old Plan does not define the benefits due under the New Plan. As the Catheys have elected substitute coverage we shall adhere to their selection and review the benefits available pursuant to the instrument alone.

The district court concluded that the nursing services at issue here were predominantly custodial, which did not merit skilled care. The court also held that the New Plan completely excludes services that are predominantly custodial. We have no quarrel with the court's factual determination that the registered nurse cooked, fed, bathed, and clothed Cathey, who, all agree, cannot execute these rudimentary chores on her own. There is also no dispute that the registered nurse administered Cathey's medications, monitored her blood pressure and bedsores,

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Footnote 7 continued.

> Home Health Care: Home health care services are those provided to a covered person in his or her home after discharge from a hospital or convalescent care facility. Typical services available through approved home health care agencies—and eligible for Plan coverage—include those of registered nurses, licensed practical nurses, home health aides, and inhalation, physical, and speech therapists. *However, expenses related to services for housekeeping or custodial care are not covered by the Plan.*
>
> . . . . .
>
> *The Plan covers 100% of the reasonable and customary charges for a maximum of 50 home health care visits to any covered individual in any calendar year.* [Emphasis added.]

performed some physical and speech therapy, and observed for and treated potential seizures.

The Dow program argued, and the district court agreed, that the nurse's gratuitous household chores, such as cooking and bathing, rendered her work predominantly custodial in nature. Since the New Plan provides that "expenses related to services for housekeeping or custodial care are not covered by the Plan," recovery for such nursing care was held to be entirely unavailable.

[5] On appeal, the Catheys argue that the strict language of the New Plan does not foreclose recovery for custodial services and, alternatively, that the registered nurse's services were not primarily custodial. They suggest that an independent provision of the New Plan compensates beneficiaries for eighty percent of home nursing services. Specifically, the provision entitled "Personal Physician" maintains that "the Plan will pay 80% of the reasonable and customary charges for such services as . . . [r]egistered nurses" that are prescribed by a physician.

The Catheys invite us to interpret the instrument so as to eviscerate the separate fifty-visit "Home Health Care" restriction, holding that two separate avenues for compensation of home nursing care are available. The Catheys ignore the fact that the prescribed services outlined under the "Personal Physician" section are plainly directed at non-home medical care, such as doctor or hospital visits. The Catheys, we conclude, offer a strained interpretation of the relevant portions of the instrument, and we decline to interpret such provisions contrary to their plain meaning or in a manner rendering certain "obstructive" language inoperative.

The "Home Health Care" provision, for instance,

limits home nursing expressly to fifty home visits per year; "Personal Physician" coverage, by comparison, targets prescribed non-home medical services generally, providing eighty percent recovery for, among other things, doctor's fees, immunizations, certain medical tests, and in-patient or out-patient registered nurses. We conclude that the measure of *home nursing* benefits due under the New Plan is provided exclusively by the "Home Health Care" provision. The measure of recovery available for in-patient or out-patient nursing care is addressed elsewhere in the instrument such as under the "Personal Physician" coverage relied upon by the Catheys here.

[6] We depart with the district court, however, in its legal determination that nursing services, if predominantly custodial, foreclose recovery for home nursing care completely. Such a construction of the instrument would, as the Catheys recognize, have the perverse effect of penalizing beneficiaries and participants for gratuitous custodial services provided by attendant home nurses. We reject such an interpretation of the instrument as not being supported by its plain language.

All agree that the New Plan compensates beneficiaries and participants for non-custodial home nursing services, albeit not beyond fifty home visits annually. Further, the Catheys admit that the New Plan's home-health-care provision does not compensate home care nurses for purely gratuitous household or custodial chores. Consequently, problems arise where, as here, there is a mix of custodial and non-custodial services performed by home care nurses.

Significantly, only expenses *related to* housekeeping or custodial care are excluded by the New Plan. Accordingly, we conclude that the fiduciary is not free to reject, in

total, claims where a portion of the nursing services is noncustodial and otherwise covered by the plan. Under the instrument's language, the fiduciary remains obligated to honor those *portions* of claims that represent noncustodial home nursing care and are medically prescribed. Specifically, the fiduciary cannot reject claims outright because the home care nurse decides, as here, to serve additionally as a companion, thereby transforming the nature of the services rendered allegedly from fully recoverable into fully nonrecoverable.

By concluding that "predominantly custodial" services foreclose home nursing benefits completely, the district court had no occasion to calculate the percentage of Cathey's rejected claims, if any, representing noncustodial nursing services. We need not remand for such a calculation, as all past nursing services were honored (Private nursing costs were not incurred after termination.), and the Catheys seek only *reinstatement* of past services or, better yet, around-the-clock care.

Thus, in summary, we affirm the district court in its conclusion that the Catheys are not entitled to around-the-clock nursing benefits under the terms of the New Plan. However, they are minimally entitled to fifty home nursing visits annually, if medically prescribed, and they are due the measure of noncustodial nursing services provided during such visits. Accordingly, we AFFIRM IN PART, REVERSE IN PART, and REMAND for further proceedings consistent with this opinion.

APPENDIX C

Filed
JUL 28 1989

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

JAMES C. CATHEY, JR., et ux,	§	
	§	
Plaintiffs	§	
	§	
	§	
VS.	§	CIVIL ACTION
	§	NO. H-87-732
	§	
THE DOW COMPANY MEDICAL CARE PROGRAM,	§	
	§	
	§	
Defendant.	§	

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Findings of Fact

1. Plaintiffs, James C. Cathey, a retiree of The Dow Chemical Company, and his wife, Bette Cathey, brought suit against Defendant, The Dow Chemical Company Medical Care Program ("Program") under 29 U.S.C. § 1132 of the Employee Retirement Income Security Act, as amended ("ERISA"). Plaintiffs, as participants covered by a health care plan of the Program, seek recovery for the Program's denial of a claim for around-the clock, in-home skilled nursing care for Mrs. Cathey.

2. The Program is an employee welfare benefit program governed by ERISA. Pursuant to ERISA, the Program provides and internal appeals precedure for claims denial.

3. The Program was restated and adopted by the Board of Directors of The Dow Chemical Company in 1982. The Plan vests its administrators with wide discretionary authority to "correct any defect, supply any omission, reconcile any inconsistency in, and to control and manage the operation and administration of the plans."

4. The Program's designated claims fiduciary is Metropolitan Life Insurance Company. Michael Maddolin is an employee of Metropolitan who acts as a claims fiduciary the discretionary authority to "review" and render the "final decision on a claim for benefits."

5. Mrs. Cathey suffers from severe multiple sclerosis and is unable to care for herself without assistance.

6. In late 1984, the Program offered an option of two distinct health benefit plans. Plantiffs had been covered by the "Old" retiree medical care plan until December 1984, when Mrs. Cathey voluntarily opted for the "New" retiree medical care plan.

7. Beginning in late October, 1982, the Plaintiffs secured the services of a registered nurse who worked one daytime shift while Mr. Cathey was still working for The Dow Chemical Company.

8. The Program paid for the services based upon claims presented to it by Plaintiffs. In late 1983 the Program's claims consultant reviewed the skilled nursing service being performed, and it was decided to continue reim-

bursement for the nurse.

9. In late 1984, a review of the claims submitted by the Plaintiffs for the in-home services of a registered nurse was undertaken by the Program's claims administrator. After receipt of detailed descriptions of the services actually being performed by the nurse, the claim was denied on January 25, 1985.

10. Plaintiffs appealed the denial of this claim through the internal appeals process, and after review, the denial was upheld.

11. The Program, in its decision on the claim, specifically advised Plaintiffs that other services such as physical therapy and periodic visits from a registered nurse for evaluation of Mrs. Cathey's condition and reporting to her Doctor were and would be covered under the terms of the New plan. These covered services continued to be performed and were paid by the Program.

12. The material provisions of the New Plan are described in the Summary Plan Description ("SPD"):

> Care is considered "custodial" when it is primarily to meet personal needs and could be performed by persons without professional skills.
>
> * * *
>
> Home health care services are those provided to a covered person in his or her home after discharge from a hospital or convalescent care facility. Typical services available through approved home health care agencies - and eligible for Plan coverage - include those of registered nurses, licensed practical nurses, home health

> aides, and inhalation, physical, and speech therapists. However, *expenses related to services for housekeeping or custodial care are not covered by the plan.* (emphasis added)

The number of such visits are limited to fifty (50) per calendar year.

13. The claim for around-the-clock, in-home skilled nursing services for Mrs. Cathey was denied by the Program on the ground that the duties prescribed by the family doctor and being performed by the registered nurse were in fact primarily custodial in nature and could be performed by a person without professional training.

14. Mrs. Cathey's doctor testifies that the duties being performed by the registered nurse were exactly the duties he prescribed. These duties included bathing, clothing, preparing of special food, feeding, assisting her into and out of her bed and in and about the home, and being a companion to her. The nurse was to give Mrs. Cathey her medication orally, check her vital signs, observe for bedsores, and to provide relief should seizures occur. The nurse also performed various speech, physical and occupational therapy exercises with Mrs. Cathey. Reports to the doctor were to be made every four months.

15. The testimony of Plaintiffs' doctor and nurse confirmed that the predominant nature of these duties were custodial in nature and did not require a skilled, registered nurse to perform although he would prefer such person. The testimony of the nurse was that the main areas requiring judgment were the therapy exercises. These services, if performed by a professional, licensed therapist, are covered by the Program.

16. Although the type of care provided by the nurse

may be necessary for the well being of Mrs. Cathey, that does not mean that the care is covered by the terms of the Program. Here it is clear that services which are " primarily custodial" are not covered by the terms of the plan. Based upon the evidence before the Court, it is clear that the care being rendered to Mrs. Cathey by the nurse was primarily custodial within the meaning of the Program's exclusion.

17. The denial of the claim for coverage of around-the-clock, in-home skilled nursing care for Mrs. Cathey by the Program was not an abuse of the discretionary decision-making authority vested in its administrators. In addition, the decision of the Program, based upon the facts presented to it at the time the decision was made, was reasonable and consistent with the terms of the Program, as interpreted by the Court on a *de novo* review.

Conclusions of Law

Any finding of fact made which is a conclusion of law is hereby adopted as a conclusion of law. Any conclusion of law made which constitutes a finding of fact is hereby adopted as a finding of fact.

2. The challenge to a decision of a Plan to deny coverage arises under ERISA, 29 U.S.C. § 1132. Unless the plan's terms vest diversity authority in the plan's fiduciaries, review of such a decision is *de novo. Firestone Tire & Rubber Co. v. Bruch*, 109 S.Ct. 948 (1989). If, however, upon review of the plan's terms, a court determines the plan's fiduciaries are vested with discretionary decision-making authority, review of the plan's decision is the "deferential standard" of abuse of discretion. *Lowry v. Bankers Life & Cas. Retirement Plan*, ____ F.2d ____ (5th Cir., April 28, 1989).

3. Based upon the Court's *de novo* review of The Dow Program's terms, the Court finds that wide, discretionary decision-making authority is vested in the Program's fiduciaries, including the authority to interpret the terms of the plan and to make final decisions on claims for coverage.

4. The decision of the Program's administrators to deny coverage for the in-home nursing services claims was proper and was not an abuse of discretion, based upon the information available to the Program at the time the decision was made. *Offutt v. Prudential Ins. Co. of America*, 735 F.2d 948, 950 (5th Cir. 1984); *Denton v. First Nat'l Bank of Waco*, 765 F.2d 1295, 1303-04 (5th Cir. 1985).

5. In the alternative and based upon the Court's *de novo* review of the Program's claim denial decision (based upon the evidence before the Program and the testimony and exhibits in this case), the Court finds that the decision the Program's terms.

6. In this case, there is no evidence of any bad faith or impermissible conflict of interest which would warrant any inference of improper decision making. *See Dennard v. Richards Group, Inc.*, 681 F.2d 306, 314 (5th Cir. 1982); *Lowry, supra*, slip op. p. 3299.

7. Only those expenses actually incurred by Plaintiffs for private duty registered nursing care would be recoverable had the court found the Program's decision to be arbitrary and capricious. No expenses for these services were actually incurred by the Plaintiffs after denial of coverage by the program, so no recovery for past benefits could be had, in any event. Since the Plan's decision was not arbitrary and capricious, no order requiring future coverage is warranted.

8. Costs of suit are awarded to Defendant.

Signed this 29th day of June, 1989 at Houston, Texas.

/s/ Norman W. Black
NORMAN W. BLACK
UNITED STATES DISTRICT JUDGE

APPENDIX D

Filed
JUL 3 1989

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

JAMES C. CATHEY, JR., et ux,	§	
	§	
Plaintiffs	§	
	§	
	§	
VS.	§	CIVIL ACTION
	§	NO. H-87-732
	§	
THE DOW COMPANY MEDICAL CARE PROGRAM,	§	
	§	
	§	
Defendant.	§	

FINAL JUDGMENT

Pursuant to the Findings of Fact and Conclusions of Law signed this date Judgment is hereby entered for Defendant.

Signed this 29th day of June, 1989 at Houston, Texas.

/s/ Norman W. Black
NORMAN W. BLACK
UNITED STATES DISTRICT JUDGE

APPENDIX E

James C. CATHEY and Bette Cathey, Appellants,

v.

METROPOLITAN LIFE INSURANCE CO. the Dow Chemical Co., and Michael H. Maddolin, Appelles.

No. 01-88-00046-CV.

Court of Appeals of Texas, Houston (1st Dist.).

Dec. 22, 1988.

Rehearing Denied Jan. 18, 1989.

Employee and his wife brought action against employer, insurer, and insurer's employee for wrongful denial of his claim for nursing home services for care of the wife. The 113th District Court, Harris County, Geraldine B. Tennant, J., entered summary judgment in favor of defendants and employee and his wife appealed. The court of Appeals, Sam Bass, J., held that: (1) employer's insurance program was an ERISA plan; (2) common-law claims based on breach of contract, negligence, and breach of duty of fair dealing were preempted by ERISA; (3) claims under the Deceptive Trade Practices Act and the Insurance Code were preempted; (4) statutes under which plaintiffs sued were not statutes regulating insurance; and (5) preemptive effective ERISA applied to employee of plan administrator.

Affirmed.

James W. Patterson, Patterson & Patterson, Joe K. Longley, Mark L. Kincaid, Longley & Maxwell, Houston, for appellants.

A.J. Harper, II, Katherine D. Hunt, Fulbright & Jaworski, Houston, Ace Pickens, Thomas W. Bullion III, Brown, Maroney, Rose, Barber & Dye, Austin, Alvin Pasternak, Donald J. Harman, James Lenaghan, William Toppeta, New York City, for Metropolitan Life Ins. Co.

Before WARREN, STEPHANOW and SAM BASS, JJ.

OPINION

SAM BASS, Justice.

James and Bette Cathey appeal from a summary judgment in favor of Metropolitan Life Insurance Co. (met), Dow Chemical Co. (Dow), and Michawl H. Maddolin. The appellants alleged multiple common law and statutory causes of action for: (1) breach of contract under Tex.Ins.Code Ann. art. 3.62 (Vernon 1981); (2) unfair insurance practices in violation of Tex.Ins. Code Ann. art. 21.21, sec. 16 (Vernon 1981); (3) deceptive trade practices, unfair insurance practices, and unconscionable conduct in violation of Tex.Bus. & Com.Code Ann. secs. 17.46(b), and 17.50(a)(4) (Vernon 1987); as well as (4) breach of the duty of good faith and fair dealing, negligence, and gross negligence. Appellants did not assert any causes of action under the Federal Employee Retirement Income Security Act (ERISA) 29 U.S.C. § 1144 (1985).

The trial court found each cause of action was preempted by ERISA. Appellants were offered the opportunity to amend their petition to assert a cause of action under

ERISA but expressly refused to do so. The court then dismissed the suit.

We affirm.

Appellants seek recovery for wrongful denial of appellant's claim for in-home nursing services by the Dow Company Medical Care Program ("Dow Plan" or "Plan"). Because this is a summary judgment case, the facts shown by the Catheys must be taken as true. *See Nixon v. Mr. Property Management Co.*, 690 S.W.2d 546, 548-49 (Tex.1985). James Cathey was employed as a purchasing agent for Dow. During Cathey's employment, he was told by Dow representatives that he and his wife were covered by a group insurance plan. In the mid-1970's, Mrs. Cathey acquired multiple sclerosis, and eventually reached a point of disability where she could not walk without assistance. In 1982, Cathey's doctors ordered nursing care for her. These expenses were paid for under the group insurance plan carried by Met covering Dow employees. In 1985, appellee Met, acting as the claims administrator for the Dow Plan, denied certain claims for nursing care expenses under certain provisions of the Plan. Maddolin, a claims consultant for Met, evaluated the claims during his employment with Met. Dow, the Plan administrator, upheld the denial of the claims.

[1] ERISA is a pervasive regulatory scheme for "employee benefit plans." The scope of ERISA's pre-emption of state law is delineated in three sections of the statute. The "pre-emption clause" of ERISA, 29 U.S.C. § 1144(a), provides that ERISA supercedes all state laws insofar as they "relate to any employee benefit plan;" however, ERISA's "savings clause," 29 U.S.C. § 1144)b)(2)(A), excepts from the preemption clause any state law that "regulates insurance." ERISA's "deemer clause"

29 U.S.C. § 1144(b)(2)(B), provides that no employee benefit plan shall be deemed to be an insurance company for purposes of any state law purporting to regulate insurance." In sum, a state law is pre-empted if it "relate[s] to" an employee benefit plan unless it is a state law that "regulates insurance." However, a state cannot "deem" an employee benefit plan to be an insurer in order to regulate the plan under state laws regulating insurance companies.

[2-4] Appellants argue that the pre-emption provision of ERISA is not applicable because none of the defendants are an "employee benefit plan" and hence, appellants' claims do not "relate to" a "plan." We do not agree. There are three general types of "plans" regulated by ERISA: (1) an employee welfare benefit plan; (2) employee pension benefit plans; and (3) plans that are both an employee welfare benefit plan and an employee pension plan. An "employee welfare benefit plan" provides medical and other benefits in the event of sickness, accident, disability, death or unemployment. An "employee pension benefit plan" provides retirement or deferred income to employees. 29 U.S.C. § 1002(1), (2)(A), (3). The Dow Plan is an ERISA plan. ERISA applies to any employee benefit plan, fund, or program, established or maintained by any employer, to the extent such plan is "maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability. . . ." 29 U.S. C. § 1002(1). The Dow Plan is an employee welfare benefit plan since it provides medical benefits and is established and maintained by Dow, an employer engaged in commerce. 29 U.S.C. § 1003(a). Pursuant to the ERISA requirements, Dow is the designated Plan Administrator and a named fiduciary for the Plan. *See* 29 U.S.C. §§ 1002(16)(a) and 1102(a). Dow, as Plan Sponsor, has designated Met as the Plan's claims

administrator pursuant to 29 U.S.C. § 1133(2) and the regulations issued thereunder.

[5] The phrase "relate to" was given its broad common-sence meaning in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983), such that a state law "relate[s] to" a benefit plan "in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Id.* The appellants' complaint alleges several state common law causes of action: breach of contract, negligence, gross negligence, and breach of the duty of good faith and fair dealing. Appellant asserts statutory causes of action of unfair insurance and deceptive trade practices under the Texas Insurance Code and the Texas Business & Commerce Code. The causes of action asserted in the appellants' complaint, each based on an alleged improper denial of a claim under an employee benefit plan, "relate to" an employee benefit plan and therefore, fall under ERISA's express pre-emption clause. *See Pilot Life Ins. Co. v. Dedeaus*, 481 U.S. 41, 107 S.Ct. 1549, 1553, 95 L.Ed.2d 39 (1987). Unless these causes of action fall under an exception in section 1144(b)(2)(A) or (B), they are expressly pre-empted.

It is well-settled that ERISA preempts state common law causes of action relating to an employee benefit plan in favor of the development of federal common law. *See Pilot Life Ins. Co. v. Dedeaux*, 107 S.Ct. 1549; *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 107 S.Ct. 1542, 95 L.Ed.2d 55 (1987). The Supreme Court gave two reasons for rejecting the argument that the state common law of bad faith was a law regulating insurance. First, "in order to regulate insurance, a law must not just have an impact on the insurance industry, but be specifically directed toward that industry." *Id.* 107 S.Ct. at 1554. The court found that even though bad faith law is often applied to the

insurance industry, "the roots of this law are firmly planted in the general principles of [state] tort and contract law." *Id.* the law applies to any breach of contract, not just breach of an insurance contract. Second, the [state] bad faith law fails to meet the indicia of laws that relate to "the business of insurance" developed under the McCarran-Ferguson Act, 15 U.S.C. § 1011 (1984). Three criteria have been used to determine whether a practice falls under the "business of insurance" for purposes of the McCarran-Ferguson Act:

> First, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry. *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129, 102 S.Ct. 3002, 3009, 73 L.Ed.2d 647 (1982) (emphasis omitted).

[6] The Cathey's complaint, with respect to its common law claims, fails for the same reasons. Their common law claims are not based on laws "specifically directed toward [the insurance] industry." The laws of negligence and breach of contract are applicabale to any tort or contract causes of action, not only those directed toward the insurance industry. For the reasons given above, we conclude that appellants' common law claims are not based on laws regulating insurance and, therefore, are pre-empted by ERISA.

This case also presents the question of whether ERISA preempts a claim for damages under the Tex.Ins.Code Ann. art. 3.62, art. 21.21, and the Tex.Bus. & Com.Code Ann. sec. 17.50(a)(4) (DTPA). *Gorman v. Life Ins. Co. of North American*, 752 S.W.2d 710 (Tex.App.—

Houston [1st Dist.] 1988, writ requested), is a case similar to the one at issue. The appellants filed suit against both Tenneco and LINA, pleading common law causes of action for: (1) breach of contract, (2) common law fraud, (3) breach of fiduciary duty, (4) breach of duty of good faith and fair dealing, and (5) negligence. Appellants also pled statutory causes of action for violations under Tex.Ins.Code Ann. art. 21.21 (Vernon Supp. 1988). The court recited that the jury found Tenneco misrepresented material facts, breached its fiduciary duty, and breached its duty of good faith and fair dealing. *See Gorman,* 752 S.W.2d at 712. From these findings, however, it is not clear that the jury found a violation of any of the statutes specifically regulating insurance, and the court did not discuss whether the causes of action under the Tex.Ins.Code and the DTPA might be saved by 29 U.S.C. § 1144(b)(2)(A).

[7,8] The Texas Legislature has declared that the purpose of art. 21.21 is "to regulate trade practices in the business of insurance." Tex.Ins.Code Ann. art. 21.21(1). Thus, art. 21.21 does not "just have an impact on the insurance industry," it is "specifically directed toward that industry." *Pilot Life,* 107 S.Ct. at 1554. Article 21.21 satisfies the U.S. Supreme Court's common-sense test for a law that "regulates insurance." *Id.* Article 21.21 also comes within the definition of a law relating to the "business of insurance" under the McCarran-Ferguson Act. *Union Labor,* 458 U.S. at 129, 102 S.Ct. at 3008. Article 21.21 regulates the terms of certain insurance contracts, and so seems to be saved from pre-emption by the savings clause as a law "which regulates insurance." Nonetheless, the language of the subsequent section of ERISA, the "deemer clause," states that an employee benefit plan shall *not* be deemed to be an insurance company "for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks,

trust companies, or investment companies." 29 U.S.C. § 1144(b)(2)(B). While a bona fide insurance company may not cease to be engaged in the business of insurance when it sells a policy to an employee benefit plan for the benefit of plan participants, *Goodrich v. General Tel. Co.*, 241 Cal. Rptr. 640, 195 Cal.App.3d 675, *review granted*, 242 Cal.Rptr. 732, 746 P.2d 871 (1987), Congress clearly did not intend employee benefit plans to be regulated under state insurance regulation laws. The deemer clause makes explicit Congress' intention to exempt from the savings clause laws regulating insurance that apply directly to benefit plans. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740-41, 105 S.Ct. 2380, 2389-90, 90, 85 L.Ed.2d 728 (1985). We hold that appellants' cause of action under art. 21.21 of the Texas Insurance Code is not protected under the "savings clause," and is therefore pre-empted by ERISA.

[9] Article 3.62 is a penalty provision of the Texas Insurance Code providing remedies for a breach of an insurance contract. Article 3.62 of the Insurance Code is titled "Penalty for Delay in Payment of Losses" and provides:

> In all cases where a loss occurs and the life insurance company, or accident insurance company . . . liable therefor shall fail to pay the same within thirty days after demand therefor, such company shall be liable to pay the holder of such policy, in addition to the amount of the loss, twelve (12%) per cent damages on the amount of such loss together with reasonable attorney fees for the prosecution and collection of such loss.

Tex.Ins.Code Ann. art. 3.62.

While art. 3.62 may be specifically directed toward the insurance industry, it cannot be said to regulate the

substantive terms of insurance contracts; it is therefore pre-empted by ERISA. *See Metropolitan Life* at 742-43, 105 S.Ct. at 2390-91. In *Juckett v. Beecham Home Improvement Prod. Inc.*, 684 F.Supp. 448 (N.D.Tex. 1988), an ERISA plan participant sued for medical expense benefits that had been denied by the claims administrator for the plan. The acting chief judge held that, based on *Pilot Life* and *Metropolitan Life*, the statutory cause of action was pre-empted by ERISA.

[10] Furthermore, the Texas Deceptive Trade Practices Act is not a law specifically designed to "regulate insurance," and therefore, causes of action under this provision are not saved from pre-emption. *See Sams v. N.L. Indus. Inc.*, 735 S.W.2d 486 (Tex.App.—Houston [1st Dist.] 1987, no writ); *Giles v. TI Employees Pension Plan*, 715 S.W.2d 58 (Tex.App.—Dallas 1986, no writ); *Felts v. Graphic Arts Employee Benefit Trust*, 680 S.W.2d 891 (Tex.App.—Houston [1st Dist.] 1984, no writ).

(11) Appellants further argue that because the ERISA plan, in this case, is insured, it is subject to indirect regulation under state law citing, *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747, 105 S.Ct. 2380, 2393, 85 L.Ed.2d 728 (1987). *Metropolitan Life Ins. Co. v. Taylor*, as well as *Gorman*, all involved plans that were *fully insured*. Each decision held that the plaintiffs could not pursue remedies under state law, but were limited to pursuing remedies under ERISA.

[12,12] Appellants assert that appellees are barred from relying on the ERISA preemption as a defense since it was not affirmatively pled. Both Dow and Met pled ERISA pre-emption in their answers. Dow stated the "ERISA preempts all state law claims" in its first amended answer to the appellants' third amended petition. Met,

in its first amended answer, stated that all "state law claims of the Plaintiffs predicated upon The Dow Medical Care Program, are pre-empted by Federal Law pursuant to the terms and provisions of the Employee Retirement Income Security Act ('ERISA')." Even if appellees had not raised ERISA pre-emption in their answers, they would be permitted to do so in a motion for summary judgment. This court decided in *Gorman* that the appellees could raise ERISA pre-emption despite "their failure to raise it as an affirmative defense." *Gorman*, 752 S.W.2d at 713. The court noted that "[a] claim of federal pre-emption is a challenge to the court's subject matter jurisdiction and cannot be waived." *Id; see also International Longshoremen's Ass'n v. Davis*, 476 U.S. 380, 106 S.Ct. 1904, 90 L.Ed.2d 389 (1986); *Barry v. Dymo Graphic Sys. Inc.*, 394 Mass. 830, 478 N.E.2d 707 (1985).

[14,15] Appellants' final argument, under its first point of error, concerns the sufficiency of the affidavit of Bollinger as to the funding of the Dow employee benefit plan. Appellants assert that appellees' summary judgment proof was inadequate because the statements in the affidavit were inadmissible because they were conclusory and not founded on personal knowledge. Tex.R.Civ.P. 166a(e) states that "affidavits shall be made on personal knowledge; shall set forth such facts as would be admissible in evidence, and shall show affirmatively that the affiant is competent to testify to the matters stated therein." *Brownlee v. Brownlee*, 665 S.W.2d 222,223 (Tex.1984); Tex.R.Civ.P. 166a(e). Bollinger, the Director of the U.S. Area Benefits Department of Dow, stated that he was speaking from "personal knowledge." The affidavit expressly states that "Dow has at all times material to this suit reimbursed Met. for all monies advanced plus an expense charge thereon." The affidavit is sufficient summary judgment evidence. *See, e.g., Marek v. Tomoco Equip. Co.*,

738 S.W.2d 710, 714 (Tex.App.—Houston [14th Dis.] 1987, no writ) (in the absence of "any evidence to the contrary . . . .," a statement that the affiant "has personal knowledge of every statement contained in the affidavit . . . is sufficient to satisfy the requirements of Rule 166-A(e)); Larcon Petroleum, Inc., v. Autotronic Sys. Inc., 576 S.W.2d 873 (Tex.Civ.App.—Houston [14th Dis.] 1979, no writ) (affidavit that stated it was made on personal knowledge complied with Rule 166a(e)"). A court will not speculate whether the affiant could establish the facts contained in the affidavit if testifying from the witness stand. *A & S Elec. Contractors, Inc. v. Fischer,* 622 S.W. 2d 601, 603 (Tex.Civ.App.—Tyler 1981, no writ). The affidavit will be taken at face value. *Netherland v. Wittner,* 624 S.W.2d 685, 687-88 (Tex.App.—Houston [14th Dis.] 1981, no writ). The decision cited by appellants, *Mercer v. Daoran Corp.,* 676 S.W.2d 580 (Tex.1984), does not support their contention because that case turned on the application of the best evidence rule, which is inapplicable to the affidavit at hand.

We hold that the appellants' state common law and statutory causes of action are pre-empted by 29 U.S.C. § 1144(a), and that the trial court did not err in entering summary judgment on pre-emption grounds.

Appellants' first point of error is over-ruled.

Appellants assert, in their second point of error, that the trial court erred in granting summary judgment in favor of Maddolin. Appellee Maddolin reviewed appellants' claims in connection with his role as a consultant and employee of appellee Met. Any actions performed by Maddolin were in the course and scope of his employment for Met.

[16] For the reasons stated above, plaintiffs cannot

pursue their lawsuit againsts either Met or Dow. Any claim that they might have against Maddolin is dependent on the viability of their claim against his employer, Met. Since ERISA's pre-emptive effect applies to lawsuits asserted against a claims administrator, such as Met, it also applies to lawsuits against employees or agents of the claims administrator, such as Maddolin. *See, e.g., Belasco v. W.K.P. Wilson & Sons, Inc.*, 833 F.2d 277 (11th Cir.1987) (reach of ERISA pre-emption extends not only to the claims against CIGNA, but to claims against the insurance broker as well); *McMahon v. McDowell*, 794 F.2d 100 (3d Cir. 1986), *cert. denied*, 479 U.S. 971, 107 S.Ct. 473, 93 L.Ed.2d 417 (1987) (summary judgment in favor of corporate employer and its individual officers and directors held proper since ERISA preempts plaintiff's common law and statutory claims). Appellants herein assert state law claims against Dow, Met, and its employee Maddolin for Dow benefits. The substance of appellants' state law claims against all appellees, including Maddolin, is the same. These state law claims relate to the Dow Plan, an employee benefit plan. They are, therefore, pre-empted by ERISA, whether they are asserted against Met, against Dow, or against Maddolin. The trial court correctly granted summary judgment in favor of Maddolin.

Appellants' second point of error is overruled.

The judgment is affirmed.

APPENDIX F

ORDERS OF THE SUPREME COURT OF TEXAS
Pronounced October 18, 1989

ORDERS ON CAUSES

C-7973, PERRY MCCLENDON
v. INGERSOLL-RAND COMPANY, d/b/a INGERSOLL-RAND COMPANY; from HARRIS County; 14th district (C14-87-00768-CV, 757 SW 2d 816, 07-21-88)

The judgment of the court of appeals is reversed and the cause is remanded to the trial court

Opinion by Justice Spears
Dissenting opinion by Justice Gonzalez
Dissenting opinion by Justice Cook
joined by Chief Justice Phillips and
Justice Hecht

* * *

ORDERS ON APPLICATIONS

THE FOLLOWING APPLICATIONS FOR WRIT OF ERROR ARE GRANTED:

* * *

C-7806, PAMELA CHAMBERS GORMAN, INDIVIDUALLY AND AS ADMINISTRATRIX v. LIFE INSURANCE COMPANY OF NORTH AMERICA ET AL.; from HARRIS County; 1st district (01-86-00501-CV, 752 SW2d 710, 06-09-88) as supplemented; 2 applications

C-8323, JAMES C. CATHEY and BETTE CATHEY v. METROPOLITAN LIFE INSURANCE CO., THE DOW CHEMICAL CO., from HARRIS County; 1st district (01-88-00046-CV, 764 SW 2d 286, 12-22-88 motion for non-resident attorney to participate granted

* * *

ORDER OF COURT

THE FOLLOWING CASES ARE SET FOR SUBMISSION ON WEDNESDAY, November 29, 1989 at 9:00 a.m.:

C-7806, PAMELA CHAMBERS GORMAN, INDIVIDUALLY AND AS ADMINISTRATRIX v. LIFE INSURANCE COMPANY OF NORTH AMERICA ET AL.; from HARRIS County; 1st district (01-86-00501-CV, 752 SW2d 710, 06-09-88)

combined with

C-8323, JAMES C. CATHEY and BETTE CATHEY v. METROPOLITAN LIFE INSURANCE CO., THE DOW CHEMICAL CO., and; from HARRIS County; 1st district (01-88-0046-CV, 764 SW2d 286, 12-22-88

Total time allotted for oral argument 30-30-10 minutes

APPENDIX G

The Supreme Court of Texas
P. O. Box 12248
Capitol Station
Austin, Texas 78711
John T. Adams, Clerk

October 18, 1989

Mr. Joe K. Longley
Mr. Mark L. Kincaid
Longley & Maxwell
P. O. Box 12667
Capitol Station
Austin, TX 78711

Mr. James W. Patterson
Patterson & Patterson
1314 Texas
Houston, TX 77002

Ms. Katherine D. Hunt
Fulbright & Jaworski
1301 McKinney
Houston, TX 77010

Mr. Judson R. Wood
Vinson & Elkins
3300 First City Tower
Houston, TX 77002

Mr. Ace Pickens
Brown, Maroney, Rose, Barber & Dye
1300 One Republic Plaza
333 Guadalupe Street
Austin, TX 78701

Mr. Wiliam Toppeta
Mr. D. J. Harman/Mr. J. M. Lenaghan
Metropolitan Life Insurance Company
Law Department, One Madison Avenue
New York, NY 10001

Case Number C-8323
JAMES C. CATHEY and BETTE CATHEY vs. METROPOLITAN LIFE INSURANCE CO.,
THE DOW CHEMICAL CO., and MICHAEL H. MADDOLIN
From Harris County, First District

Counsel:

Today, the Supreme Court of Texas granted the application for writ of error in the above styled cause on the following Point/s:

Points of Error Numbers 1 and 23.

The motion of resident practicing attorney regarding admission of non-resident attorneys to participate in appeal to the Supreme Court attorneys to participate in appeal to the Supreme Court of Texas are both granted.

This cause has been set for submission and oral argument for Wednesday, November 29, 1989 at 9:00 a.m. and is consolidated for purposes of oral argument with cause number C-7806 (see enclosed letter in cause no. C-7806 for information regarding oral argument).

Please indicate on the enclosed form which attorney/s will present oral argument, (see Texas Rules of Appellate Procedure No. 172) and return the form to the Clerk's Office at your earliest convenience.

Petitioner/s hereby assessed $75.00 additional filing fee for granting the application.

Very truly yours,

JOHN T. ADAMS, Clerk

By /s/ Peggy Littlefield
Peggy Littlefield, Chief Deputy

Encl: argument form
cost bill (this letter)

APPENDIX H

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 89-2971

Filed
SEP 13 1990

JAMES C. CATHEY and
BETTE CATHEY,

Plaintiffs-Appellants,

versus

THE DOW CHEMICAL COMPANY
MEDICAL CARE PROGRAM,

Defendant-Appellee.

Appeal from the United States District Court for the
Southern District of Texas

ON PETITION FOR REHEARING
(September 13, 1990)

Before HIGGINBOTHAM, SMITH and BARKSDALE, Circuit Judges.

PER CURIAM:

IT IS ORDERED that the petition for rehearing filed in the above entitled and numbered cause be and the same is hereby DENIED.

ENTERED FOR THE COURT:

/s/ J. Smith
United States Circuit Judge

APPENDIX I

EXCERPTS FROM PLAINTIFFS' EXHIBIT 15

RETIREE MEDICAL CARE PROGRAM BROUCHURE

Medical Care Program for Retirees Under Age 65 — Old Plan:

* * *

Supplemental Benefits

What coverage do you have through Supplemental Benefits?

* * *

As with Basic Benefits, coverage applies only if the particular item of health care is medically necessary. Also, the coverage applies only to reasonable and customary charges for the care involved.

Many health care needs are met through services performed by, or prescribed by, a physician. When this happens, your Supplemental Benefits help to cover the expense of such services as:

- Doctor's office and home visits.
- Immunizations.
- Prescription drugs and medicines.
- Birth control drugs or devices fitted and prescribed by a physician.
- Registered nurses.
- Rental or purchase of some medical equipment, if Dow-approved—but rental fees cannot exceed the cost of the equipment.

- Psychotherapy treatment of a nervous or mental condition (but note the special provisions on psychotherapy treatment, outlined in a later question-and-answer).
- Orthopedic shoes having unremovable insertions or attached to a brace, when prescribed by a licensed physician and prepared by a certified orthotist prosthetist.
- Covered expenses for a stay in a hospital or convalescent care facility that foes beyond the maximum-day limit under the Basic Benefits.

* * *

What's the dollar limit on Supplemental Benefits payments?

You have a lifetime maximum of $50,000 in Supplemental Benefits for you and each of your covered dependents.

* * *

Is this the whole story on Supplemental Benefits?

Again, the answer is no. For details beyond this summary of highlights—such as specifics on coverage for services rendered in an outpatient facility for alcoholismor drug abuse—read your Certificate of Insurance or talk with the people in your local Benefits Department.

* * *

How can you get more information on this Medical Care Program

You have three sources for more details, specifics and explanations. The best sources are:

- The Certificate of Insurance.
- The group policy insurred to Dow by the Metropolitan Life Insurance Company, with all the terms and conditions of the Program.
- Your Benefits Department.

Medical Care Program for Retirees Under Age 65 — New Plan:

* * *

What's a good starting point for a basic understanding of your Medical Care Program coverage?

* * *

- The program coverage applies to necessary health care.
- *Necessary* means just that — care that's really needed. An example of health care that could involve hospital, surgical, and medical expenses without being *necessary* is plastic surgery for strictly cosmetic purposes.

* * *

Is there an out-of-pocket maximum?

Yes! Remember, the Medical Care Program is designed to protect you and your family against

serious financial hardship that could be brought on by heavy medical costs. As a shield, the Plan limits the 20% co-payment you might have to pay from your own pocket in any one calendar year for expenses covered at 80%

Above the out-of-pocket maximum, the Plan will pay 100% of the reasonable and customary charges for services normally covered at 80%, up to the maximum benefits provided by the Plan. . . .

* * *

What's the dollar limit on Plan benefits, and how does it apply?

The Medical Care Program provides you and each of your covered dependents a lifetime maximum of $1 million of total benefits from the Plan. . . .

* * *

A Summary of Coverage

After those preliminaries: What health care services of what health care provides are covered — and to what extent?

Here's your answer. It's a long one. And it's structured on a listing of health care providers and some specific medical conditions. There are lots of details. Take the time to read carefully.

* * *

Convalescent Care Facility, Inpatient: Such a

facility may be part of a hospital, or a separate institution. In either case, it serves persons who, after a hospital stay, still need medical care but not at the level a hospital provides.

For coverage by the Plan, the medical necessity of a stay in a convalescent care facility must be certified by a physician. Also, admission to the facility must be within 10 days of leaving a hospital confinement of at least three days. And, finally, the reason for the patient's continued confinement must not be "custodial."

Care is considered "custodial" when it is primarily to meet personal needs and could be provided by persons without professional skills or training.

The Plan pays 100% of the *reasonable and customary* charges for inpatient services at an approved convalescent care facility. The maximum number of days covered by the Plan depends on how many days of hospital care preceded the convalescent care. For details, check with your local Benefits Department.

* * *

Home Health Care: Home health care services are those provided to a covered person in his or her home after discharge from a hospital or convalescent care facility. Typical services available through approved home health care agencies — and eligible for Plan coverage — include those of registered nurses, licensed practical nurses, home health aides, and inhalation, physical, and speech therapists. However, expenses related to services for housekeeping or custodial care are not covered by the Plan.

Benefits are payable for home health care services when *all* the following apply:

- Arrangements for the home health care are made within 10 days of discharge from a hospital or convalescent care facility.
- A physician certifies the necessity for this care, and also the type of service, frequency and duration of treatment, and the level of professional(s) to provide the treatment.
- The required care relates directly to the condition that required the hospital or other confinement.

The Plan covers 100% of the *reasonable and customary* charges for a maximum of 50 home health care visits to any covered individual in any calendar year.

* * *

Personal Physician: Many health care needs are met through services performed or prescribed by a physician. When this happens, the Plan will pay 80% of the *reasonable and customary* charges for such services as:

- Doctor's office and home visits.
- Medical emergency room fees and related physician's fee.
- Immunizations.
- Prescription drugs and medicines.
- Birth control drugs or devices fitted and prescribed by a physician.
- Routine pap smears.
  Registered nurses.
- Rental or purchase of some medical equipment, if Dow approved — but rental fees cannot exceed the cost of the equipment.

- Orthopedic shoes having unremovable insertions or attached to a brace, when prescribed by a licensed physician and prepared by a certified orthotist prosthetist.
- Physical, occupation, or speech therapy — up to a maximum of 365 calendar days from the first date of treatment.

* * *

APPENDIX J

Michael H. Maddolin
Group Claim Consultant

Metropolitan Life
c/o Employee Benefits
Dow Houston Center
P.O. Box 42335
Houston, TX 77042

April 7, 1982

J. C. Cathey, Jr.
Box 487
Wallis, TX 77485

Re: Bette

Dear Mr. Cathey:

The Dow Chemical Medical Benefit Program provides benefits towards services rendered or prescribed by a licensed physician for the treatment of a sickness or injury when such services are medically necessary.

Services that are prescribed by a licensed physical therapist and performed by another person are not covered under the Dow Benefit Program. Services rendered for diet instructions, and that of evaluation by a social worker are also not covered under the Dow Benefit Program.

We are sorry, but based on the information that we have, at this time, there does not appear to be a medical necessity (in terms of the prevailing medical standards) involving the services rendered by the Visiting Nurse Association as there is no medical treatment being rendered other than that of custodial care. Therefore, we find it necessary to decline benefits involving services rendered by the Visiting Nurse Association.

Sincerely,

/s/ Michael H. Maddolin
Michael H. Maddolin
Group Claim Consultant

APPENDIX K

Michael H. Maddolin
Group Claim Consultant
January 25, 1985

Metropolitan Life
c/o Employee Benefits
Dow Houston Center
P.O. Box 3387
Houston, TX 77253-3387

MR. J. C. CATHEY
6027 Bowers Rd.
Wallis, TX 77485

Dear Mr. Cathey:

I have carefully reviewed Mrs. Jurek's reply to our inquiry of December 18, 1984.

Subject to further review by Metropolitan's Medical Department, it appears that only the therapy services may be eligible for continued coverage.

Skilled nursing services to satisfy a medical need of the patient are covered by the Dow group plan. However, services by a nurse which are principally to assist with the personal needs of the patient such as preparing meals, feeding, bathing, help in getting into and out of bed, movements about the house, and companionship are not within the policy provisions.

Pending final review by the Medical Department, I will advise the benefits personnel in Houston that only 3 hours attributed by Mrs. Jurek to physical, occupational and speech therapy may be covered.

Sincerely,

/s/ Michael H. Maddolin
Michael H. Maddolin
Group Claims Consultant

cc: Hugh West

APPENDIX L

Michael H. Haddolin
Group Claim Consultant

Metropolitan Life
c/o Employee Benefits
Dow Houston Center
P.O. Box 42335
Houston, TX 77042

February 12, 1985

Mr. Marvin Metcalf
Dow Chemical, U.S.A.
Benefits Department
P.O. Box 3387
Houston, TX 77235-3387

RE: REVIEW OF J.C. CATHEY NURSING EXPENSES FOR SPOUSE

Dear Marvin:

The information contained in Mrs. Cathey's claim file involving services rendered by Mrs. Jurek, R.N. has been reviewed.

Based on the information that we have, we find it necessary to advise that since there is no medical treatment being rendered other than custodial care, we must decline benefits involving services rendered by Mrs. Jurek, R.N.

Note, also, that the therapy which is being administered by Mrs. Jurek does not conform to the following guidelines and would therefore not be reimbursable:

a) Physical therapy must be prescribed by a licensed physician, deemed medically necessary for the treatment of sickness or injury, and services must be performed by a licensed physical therapist.

b) Speech therapy must be prescribed by a licensed physician, deemed medically necessary for the treatment of sickness or injury, and services must be performed by a licensed or certified speech therapist.

c) Occupational therapy must be prescribed by a licensed physican, deemed medically necessary for the treatment of sickness or injury, and services must be performed on an out-patient hospital basis by a member of the hospital staff.

If, within sixty days of the date of this letter, Mr. Cathey wishes to appeal and can provide additional information, we will be glad to review the case.

Sincerely,

/s/ Michael H. Maddolin

Michael H. Maddolin
Group Claim Consultant

pd

Plaintiff's Exhibit 20

APPENDIX M

DOW CHEMICAL U.S.A.

March 8, 1985

WILLARD H. DOW CENTER
MIDLAND, MICHIGAN 48640

Mr. James Cathey
P. O. Box 487
Wallis, TX 77485

Dear Mr. Cathey:

Enclosed is the letter from Metropolitan concerning nursing services for Mrs. Cathey. The home health aide services Mr. McArdle refers to are covered under the New Plan at 100% of the reasonable and customary cost up to a maximum of 50 visits in a calendar year for up to four (4) hours per visit, if provided through an approved home health care agency. The physical therapy services Mr. McArdle describes would be covered at 80% of the reasonable and customery charges.

I have requested that our Houston office initiate payment for the balance of the claims you submitted on 1/25/85 and 2/2/85.

Sincerely,

/s/ Hugh West

Hugh West
Employee Benefits

cc: M. Maddolin
M. Metcalf

Plaintiff's Exhibit 24

APPENDIX N

Metropolitan Life Insurance Company
c/o Employees Benefits
The Dow Chemical Company
2020 Willard H. Dow Center
Midland, Michigan 48674

Metropolitan Life
And Affiliated Companies

Frank V. McArdle
Account Consultant

March 8, 1985

Claim Identification

Employee: J.C. Cathey, Jr.
Patient: Bette

Hugh West
The Dow Chemical Company
2020 WHDC
Employee Benefits

In response to your request, we have reviewed the claim file sent to us concerning nursing services for Mrs. Cathey, commencing with a letter dated December 4, 1981 from Dr. Torp in which he indicates that the patient had been referred for VNA and Home Health Care services, up to a letter dated February 23, 1984 from Mr. Cathey seeking review of his claim for the cost of nursing care services.

The provisions of the Dow Chemical Medical Benefits Plan have been stipulated in letters from Michael Maddolin, Group Claim Consultant. In accordance with the terms of the Plan, we see no basis for coverage of full-time bedside nursing services, as full-time bedside nursing services have not been provided. Further, although Dr. Torp stipulates in his recent letter that full-time skilled nursing care is necessary, he does not describe bedside nursing services that require a graduate registered nurse to perform.

From our evaluation, however, it does seem appropriate to provide the services of a Home Health Aide to assist Mrs. Cathey with the activities of daily living, as originally prescribed by Dr. Torp, as well as a once weekly two-hour visit from VNA or other registered nurse for the purpose of checking vital signs and reporting to Dr. Torp as he wishes. It would also be appropriate to cover once weekly visits by a registered or licensed physical therapist, but we would wish to have a copy of the therapists weekly report, including a prognosis for the necessity of continued therapy, provided to Mr. Maddolin for evaluation.

We sincerely regret that this may not be coverage of all of the services which Mr. Cathey desires, but it is in accordance with the terms of the Plan.

If we can be of further service to you in this matter, please advise.

/s/ V. V. McArdle

F. V. Mc Ardle

km

PLAINTIFF'S
EXHIBIT
25

APPENDIX O

DOW CHEMICAL U.S.A.

400 WEST BELT SOUTH
P.O. Box 3387
HOUSTON, TEXAS 77001

March 15, 1985

Mr. J. C. Cathey

P.O. Box 487
Wallis, TX 77485

Dear Jim:

A provision of the New Plan which has worked in your favor is the maximum out-of-pocket expense.

If you have read the literature covering this feature, you are aware that expenses subject to 80% coverage (excluding the deductible) may be reimbursed at 100% after the amount paid by the retiree or employee reaches a certain maximum.

In your case, the maximum out of pocket is based on 2% of your annual retirement income. After age 62, the "Retirement Income" will include Social Security.

Based on Hugh West's letter of March 8, we have reconsidered all nursing expenses through February 2 under the "Maximum out-of-pocket expense" provision, and all other 1985 expenses submitted to date, and will include a makeup amount of $1097.17. The nursing charge of $600 for the week of January 28 to February 1 was detained for the final review of Metropolitan. This issue of checks will include 100% of that amount - again based on the maximum out-of-pocket provision.

Rosemary will include a copy of our review sheet which indicates all expenses processed to date in 1985 and the amounts previously paid and the makeup amounts on each expense.

Sincerely,

/s/ Marvin Metcalf

Marvin Metcalf
Benefits Manager

MM/raa

Enclosure

PLAINTIFF'S
EXHIBIT
26

APPENDIX P

DOW CHEMICAL U.S.A.

May 7, 1985WILLARD H. DOW CENTER
MIDLAND, MICHIGAN 48640

Joe K. Longley, Esq.
Longley & Maxwell
602 Brown Building
708 Colorado Street
Austin, Texas 78701

RE: J. C. CATHEY, BETTE CATHEY

Dear Mr. Longley:

I have enclosed documents in response to your request for information directed to F. V. McArdle and Marvin Metcalf. I represent The Dow Chemical Company Medical Care Program and The Dow Chemical Company as plan administrator. Metropolitan Life Insurance Company is the plan fiduciary for the payment of claims.

A booklet containing the summary plan descriptions of the retiree Medical Care Programs is enclosed. Also, I have enclosed a copy of the Medical care Program plan document, master group policy and correspondence.

The certificate of insurance for the "New Plan" is in the final stages of preparation. It should be in print within 45 days. As you know, the certificate of insurance is designed to provide more detailed information with respect to the terms of the Medical Care Program. Also, detailed information may be obtained from the Benefits Department.

With respect to nursing services, the certificate will reflect the plan intent that skilled nursing services that are not custodial care, provided by a Nurse other than a Nurse who lives in one's home or who is a member of one's immediate family may be a Covered Medical Expense with the covered percentage being 80% (unless otherwise reduced or excluded by other plan provisions). Nursing care provided through a home-health care agency may be covered at 100% (unless otherwise reduced in accordance with other plan provisions).

With respect to the claim review procedure, please refer to page 24 of your "Retiree Medical Care Program" booklet. A copy of the "Welfare Benefit Plan Claims Procedure" is enclosed as well.

If you have any questions, or concerns, please contact me at (517)636-3200. If you wish, I will provide you with a copy of the summary plan descriptions for all of the Dow benefit plans and programs for active employees as well.

Sincerely yours,

/s/ C.A. Wadsworth
C. A. Wadsworth
Attorney
Legal Department

1f/enclosures

cc: Frank McArdle
Hugh West

PLAINTIFF'S
EXHIBIT
30

APPENDIX Q

EXCERPTS FROM PLAINTIFFS' EXHIBIT 38

METROPOLITAN LIFE INSURANCE CO CERTIFICATE OF INSURANCE

Metropolitan Life Insurance Company
A Mutual Company Incorporated in New York State

The Insurance Company certifies that under and subject to the terms and conditions of Group Policy No. 11700-G issued to

THE DOW CHEMICAL COMPANY

insurance is provided for each Employee as defined in this certificate.

* * *

SUPPLEMENTAL MEDICAL EXPENSE INSURANCE

SECTION A.

BENEFIT PROVISIONS

To obtain Supplemental Medical Expense benefits, you or your Dependent must be insured when one or more of the covered medical expenses listed below are incurred during a medical expense period, and the expense or expenses must be greater than the deductible amount specified in the Hospital Expense Insurance and Surgical — Medical Expense Insurance section. It is not necessary to be confined in a hospital to be eligible for benefits.

For explanation of some of the terms used in this section, see the "Definitions" section of this coverage and of the Hospital Expense Insurance and Surgical — Medical Expense Insurance section.

Metropolitan will pay 80% of covered medical expenses which exceed the deductible amount in any medical expense period, except that

1. Benefits for any one covered person's expenses are limited to a lifetime maximum of $50,000. However, if, at any time, $1000 or more has been paid by Metropolitan for covered medical expenses for any one covered person, and you submit proof of the good health of that person to Metropolitan, the amount of benefits available to you from the date Metropolitan accepts such proof will not be reduced by the amount of benefits previously paid.

* * *

Section B.

DEFINITIONS

1. Covered Medical Expenses

"Covered Medical Expenses" means reasonable, necessary and customary charges for the types of medical services shown below. These services must be

A. performed or prescribed by a physician,

B. rendered to a covered person for the treatment of injury or sickness,

C. medically necessary in terms of prevailing medical standards.

In the case of a fee, such fee must be in accordance with the reasonable, necessary and customary range of fees, as defined in the Hospital Expense Insurance and Surgical — Medical Expense Insurance section.

The following are covered medical expenses:

* * *

private duty bedside nursing services of a registered graduate nurse at home or in a hospital, provided the nurse does not ordinarily live in your home and is not a member of your immediate family,

* * *

APPENDIX R

EXCERPT FROM DEFENDANT'S EXHIBIT 4
Listing of Group Insurance Library
relating to Nursing Services, dated March 18, 1982

* * *

NURSES

Medically necessary private duty nursing services performed by a registered nurse or licensed practical nurse are covered under the supplemental plan. If the nurse is a member of the immediate family or resides in the employee's home, charges for the nurse are not covered. Our certificate says private duty, bedside nurses, in the home or hospital are covered. But we will still cover a nurse who goes to the home to administer drugs.

We will need a statement from a physician stating that the services are medically necessary, also with the following data:

1. Reason indicating the medical necessity.

2. Services to be performed by the nurse

3. Present condition of the patient

4. Approximate length of time the nursing services will be required.

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3/18/82